

Resident
Admission Contract of ManorCare Bethesda

This Contract Has Been Approved by The Maryland
Department of Health and Mental Hygiene

1. This Contract is between Manorcare of Bethesda (the "Facility", or "we", or "us") and William Bevan (the "Resident" or "you"). This contract contains your financial obligations, as well as your rights as a Resident of this Facility.

2. In consideration of your payment and promises made in this Agreement, the Facility agrees to do the following:

Health Care Services

A. We will provide you with general nursing care and nursing treatments such as administration of medication, preventive skin care, assistance with bathing, toileting, feeding, dressing and mobility. (Throughout this Agreement is information about which services are covered in the Facility's daily rate and which are available for an additional charge.)

B. When your doctor orders health care services which we do not have the capability to provide, with your approval we will arrange for the services to be provided by an outside provider, or we will arrange for your transfer to the hospital or other health care providers.

Personal Services

C. We will provide you with room and board, housekeeping services, recreational and social programs, and personal care.

D. We will provide you with a reasonable amount of storage space for your personal belongings.

E. At your request, we will maintain your personal funds in compliance with the laws and regulations relating to our management of your funds. See Exhibit 4.

3. Paying for Your Care.

A. Who Can be Required to Pay for Your Care.

Only you and your insurer can be required to pay for your care. No other person - e.g., a family member, friend, neighbor, legal agent or guardian - can be required to pay for your care from their own funds, although he or she may knowingly and voluntarily agree to pay for the cost of your care.

We require you or any other person responsible for making payments on your behalf to pay for your care under the terms of this contract in a timely manner. If you or anyone else with authority to pay for your care on your behalf fails to pay a Facility bill, we may request a court to order such payment.

You agree to provide all information requested by us about your health and financial status and to update this information while you are a resident here. You understand that if we later find that you knowingly or willfully provided us with incomplete or inaccurate information, we will consider that as a breach of this Agreement which gives us the right to pursue all legal remedies against you.

It is anticipated that your care will be paid for by:

- ☐ The Medicare Program;
- ☐ The Medicaid Program (also known as "Medical Assistance");
- ☐ Other third-party insurer (please specify: _____);
- ☐ You with your own funds; or
- ☐ Another person with your funds (please specify: _____);
- ☐ Another person who has voluntarily agreed to pay with their own funds (please specify: _____).

It is understood that Medicare and Medicaid will make the determinations concerning your medical and financial eligibility for payment by those programs.

You agree to pay either directly or through a third party payor for all items and services provided to you by the Facility. You request that the Facility send your bills to:

_____.

B. Private Pay Residents.

The items and services included in our daily rate of See rate sheet include basic room, board and general nursing care as required by your medical condition and are listed in Exhibit 1. Payment for items and services that are included in the daily rate is payable one month in advance and due on the first of each month, and you (or your agent) agree to make timely payment.

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You will be charged separately for additional items and services which you or your physician, with your approval, request and which are not included in our daily rates such as special nursing care, special equipment, pharmacy charges, laboratory charges and additional services such as telephone expenses, clothing, beauty and barber services and newspapers. A list of many of the ordinary items and services for which you may be charged is at Exhibit 1. If you (or your physician, with your approval) request items or services other than those listed in Exhibit 1, you will be notified of the cost. Payment for these additional items and services is due within thirty (30) days after you (or your physician with your approval) have requested them, and you have received and have been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment, you have the right to ask us for an itemized statement that briefly but clearly describes each item and service, the amount charged for it, and the identity of the payor billed for the service.

You understand and agree that you (or your agent) are responsible for paying the Facility for items and services provided to you during any period of time in which you are or were a resident of the Facility and during which you have not been determined eligible for Medical Assistance. If you (or your agent) do not pay the amount you owe us after receiving Facility bills, and we hire a collection agency or attorney, you agree to pay for their fees, expenses and costs.

If you do not pay what is owed the Facility, you agree to apply to Medical Assistance for a determination of your income and assets available to pay the cost of your care. Once

Medical Assistance determines the income and assets available to pay for your care, you agree to use such income and assets to pay the Facility's bills.¹ (Your request for this determination is not the same as applying for Medical Assistance.)

You agree to notify the Facility promptly if you have insufficient income, funds or assets, to meet your financial obligations to the Facility and you agree promptly to apply for Medical Assistance benefits. You agree to cooperate fully in applying for Medical Assistance and in the eligibility determination process. If you do not apply or cooperate fully in the process, the Facility may ask a court to order you to do so.

If you are no longer able to pay for your care at the Facility and you are not eligible for Medical Assistance, you will be notified of the Facility's intention to discharge you for non-payment. You agree to continue to pay the Facility's prevailing daily charges until the date of your departure.

If there is any dispute about whether you should be discharged, the notice and other requirements in Section 4.F. apply. If transfer or discharge becomes necessary because you or someone else abused your funds, the Facility will request that the Attorney General investigate which may result in prosecution.

¹ If you do not request a determination by Medical Assistance, or if payment is not made with the income and assets determined to be available for your care, the Facility may ask the court to order you to obtain the determination or to make payment.

If you believe that you may need to apply for Medical Assistance later, you may want to find out now if you are "medically eligible" for nursing home payment by Medicaid. See Exhibit 2B. This is not, however, the same as applying for Medical Assistance.

C. Medicare Residents

We participate in the Medicare Program. Medicare may pay for some or all of your nursing home care. For information on Medicare, see Exhibit 2A. If you are eligible for Medicare, you have the right to have claims for your nursing home care submitted to Medicare. If Medicare agrees to pay for your care, you understand that Medicare requires a co-payment (for most covered services) and you agree to make the required co-payment, currently \$170.50, which Medicare changes yearly. You also understand that some items and services offered by the Facility are not covered by Medicare and if you want any of these items or services, you agree to pay for them. (A list of the items and services not covered by Medicare and charges for them are at Exhibit 3.) If you also participate in Medicare, Part B, for physical, occupational, or speech therapy or other billable charges (which are not covered by Medicare, Part A), you agree to pay any required deductible, and any applicable co-insurance.

D. Medicaid Residents.

We participate in the Medicaid program. For information on Medicaid, see Exhibit 2A. You are not required to give up any of your rights to Medicaid benefits to be admitted or to stay here. If your private funds are used up during your stay

here and you are eligible for Medicaid, we will accept Medicaid payments.

You are responsible for applying for and obtaining Medicaid benefits and we will assist you, by promptly providing Medical Assistance with all required information in our possession. We may not charge, ask for, accept or receive any gift, money, donation or consideration other than Medicaid reimbursement as a condition of your admission or continued stay here.

If you receive Medicaid, most of your nursing home charges such as room, board and general nursing care are covered, although Medicaid may require you to pay some amount from your monthly income. The local Department of Social Services will tell you whether you have to pay part of the charge for your care and, if so, how much. You understand and agree to pay on a timely basis this contribution amount as determined and periodically adjusted by the local Department of Social Services. If you (or anyone else with authority to pay) fails to pay this amount, we may request a court to order such payment.

A list of the items and services covered by Medicaid are posted (which are published at COMAR 10.09.10.04) in the Facility at the following location: Reception desk and Administrator office.

If you would like your own copy the Facility will give you one.

Some of the items and services that we offer are not covered by Medicaid. If you want any items or services which are not covered by Medicaid, you or your agent will have to pay for

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them. A list of the items and services not covered by Medicaid and the charges for them are at Exhibit 3. Payment for items and services that are not covered by Medicaid is due after you or your physician with your approval have requested them and you have received and have been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment you have the right to ask us for an itemized statement that briefly but clearly describes each item and the amount charged for it, and the identity of the payor billed for the service.

You understand that non-payment of items and services not covered by Medicaid may result in a discharge action for non-payment of bills. If all of your personal needs have been met, you understand that money in your personal funds account may be needed to pay for items and services not covered by Medicaid which were requested by you (or your physician, with your approval) and are provided by the Facility.

E. Increases in Charges and Fees.

Any time we increase a fee or charge for an item or service or add a new item or service, we will provide you and your agent with forty-five (45) days advance written notice.

F. Interest Penalties.

We may not charge you a penalty if you pay your bill on time. Your payment is on time if it is made within 45 days of the date the itemized statement is postmarked, or 30 days after the end of the billing period, whichever is later. The interest penalty we charge is _____% of the amount due, calculated on either a () daily or ()

an attorney to prepare a financial Power of Attorney. As part of the admission process, you will be given a description of your legal rights to decide about your future medical treatment, as well as information about making advance directives. If you make an advance directive, you should provide the Facility with a copy.

B. Selection of a Doctor or Other Provider.

You may select your own doctor and other health care providers. Your doctor and other health care providers must follow our policies.³ You or your insurer, including the Medicaid Program, is responsible for your doctor's payment. If you do not have your own doctor, you may choose one from the list of physicians who practice here.

This list is attached as Exhibit 5. If you or your agent are unable to choose your own doctor, we will assign one to you from this list. In case your doctor is not available when needed, our Medical Director, or designee, will take care of you until your doctor is available.

Some services you may require are available through outside providers. Some available outside providers and whether the Facility has a shared ownership interest with the Provider are at Exhibit 6.

C. Your Personal Property and Financial Affairs.

³ If your doctor and other health care providers do not follow Facility policies and procedures, the Facility will ask you to choose other providers.

You have certain rights relating to your personal property and managing your financial affairs. The Facility's policy and procedure concerning these rights is at Exhibit 4.

D. Your Right to Make Complaints and Suggest Changes in Policies and Services.

You may make complaints about your care in the Facility and you may also suggest changes in the policies and services of the Facility. You will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or service. You may present your complaints orally or in writing to Facility staff or the Administrator, or to one of the following State agencies:

Office of Health Care Quality	Department on Aging
Bland Bryant Building	301 West Preston St
Spring Grove Hospital Center	Room 1004
55 Wade Avenue	Baltimore, MD 21201
Catonsville, MD 21228	
(410) 402-8110	(410) 767-1074
(877) 402-8219	(800) 243-3425
(800) 735-2258 (TTY)	(410) 767-1083 (TTY)
(410) 402-8234	(410) 333-7943
(Facsimile)	(Facsimile)

If the Facility is unable to resolve your complaint, it will be sent to the Office on Aging and the Licensing and Certification Administration. You may request a hearing from that Administration.

E. Holding Your Bed if You Leave the Facility.

If you are hospitalized or on leave from the Facility, we will hold your bed for you as follows:

1. If you are a private-pay resident, or are receiving inpatient care reimbursed under the Medicare Program (and you are not covered under Medicaid), we will hold your bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

2. If Medicaid pays for part or all of your nursing home care and you need to be hospitalized, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently 0 days. If you are away from the Facility on a leave of absence which is provided for in your plan of care and approved by your physician, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently 0 days each calendar year. While we are holding your bed, you are still required to pay the Facility any amount for which you are responsible as determined by the Medicaid Program.

If your hospitalization or leave exceeds the number of days paid by the Medicaid Program, you may pay privately to reserve your bed for the additional days. In any case, if your hospitalization or leave of absence exceeds the total number of days paid by the Medicaid Program or any other payer, you have the right to be readmitted to the first available gender-appropriate semi-private bed.⁴

⁴ Semi-private means a two, three or four-bed room.

The maximum number of days for which the Medicaid Program will pay to hold your bed for hospitalization or leave of absence may be increased or decreased based upon changes in the law or the regulations established by the Maryland Medical Assistance Program.

3. If you have applied for Medicaid, your bed will be reserved in accordance with Paragraph 2. However, if you are found to be ineligible for Medicaid, then you are required to pay for the bed as a private pay patient as described in Paragraph 1.

4. Other third-party payors may or may not have a bed hold policy. We will discuss this if it applies to you.

F. Transfer and Discharge.

You have the right to remain here, and you may not be transferred or discharged against your will, except for the following reasons: (a) your condition has improved so that you no longer need the services we provide; (b) the transfer or discharge is necessary for your welfare and your needs cannot be met by the Facility; (c) the health or safety of an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay (or through your insurers have failed to pay) for a stay at the Facility; or (e) the Facility ceases to operate.

If the Facility identifies one of these reasons for transfer or discharge, we will notify you and your family member, guardian, or representative by letter 30 days in advance. We also will notify the Office of Health Care Quality and the Department on Aging. If you are

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transferred because of an emergency situation, we will provide the required notice as soon as reasonable. The involuntary discharge letter will contain the reasons for the transfer or discharge and its effective date, the location to which you will be transferred or discharged, and your rights regarding discharge or transfer. The letter will also tell you how you can appeal our decision to transfer or discharge you, by requesting a hearing, and will tell you what agencies you can call for assistance.

If you are to be discharged involuntarily, we will comply with current law in making discharge or transfer arrangements.

You and your next of kin or legal agent must cooperate and assist in the discharge planning, including cooperating with and assisting other facilities considering admitting you and cooperating with governmental agencies. If you or the Facility believe that an abuse of funds contributed to the transfer or discharge for non-payment, you may, or the Facility will, ask the Attorney General to investigate and make referrals to other governmental agencies.

5. Your Right to End This Contract.

If you decide to end this Contract and leave the Facility, your bill becomes due and payable on the day you leave. You must give us 3 days notice to terminate this contract. If you leave before the end of that time, you must still pay for each day of the required notice unless we fill the bed before the end of the notice period.

In the event you die while a resident of the Facility, please designate who you want us to contact:

Relative or Friend:

Funeral Home:

Unless you have instructed us otherwise, we will immediately contact the individual(s) listed above to make funeral arrangements. If we are unable to reach the individual(s), we will contact the funeral home directly.

6. Additional Documents.

It is not possible to cover everything that is important to your stay in our Facility in the body of this Contract. Therefore, we have included additional important documents as Exhibits. These Exhibits are part of this Contract. Please verify that you received the Exhibits and that the contents of the Exhibits were explained to you by placing your initials on the line next to the description of each Exhibit.

WB Exhibit 1. Private Pay:

- A. Items and Services Included in the Daily Rate;
- B. Items and Services Not Covered by the Daily Rate.

WB Exhibit 2.

- A. How to Apply For and Use Medicare and Medicaid Benefits.
- B. Medical Assistance Nursing Facility Services (Medicaid Medical Eligibility Form)

WB Exhibit 3. Items and Services Not Covered by Medicare or Medicaid.

WB Exhibit 4. Policies and Procedures Concerning Your Personal Funds and Your Personal Property.

WB Exhibit 5. Physicians Who Practice at the Facility.

WB Exhibit 6. Services Provided by Outside Health Care Providers.

7. Changes In Law.

Any provision of this Contract that is found to be invalid or unenforceable as a result of a change in State or Federal law will not invalidate the remaining provisions of this Contract and, it is agreed that to the extent possible, the Resident and the Facility will

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continue to fulfill their respective obligations under this Contract consistent with the law.

IN WITNESS WHEREOF, the parties have executed this Contract on this 27th day of August, 2019.

WITNESS:

ManorCare Bethesda

WITNESS:

Kayden Swan

By:

Name:

Title: Admissions Coordinator

RESIDENT:

Kayden Swan

ManorCare Health Service – Bethesda

Schedule of Services & Charges

All room and board rates include: routine 24-Hour nursing care, meals and snacks, housekeeping and linen services, recreational activities, social service consultation and personal care.

Type of Room	Monthly Rate*	
Private Room	\$13,057.20	\$421.20
Semi-Private	\$11,767.60	\$379.60

*Above rates apply to Hospital Bed Holds (exception for Medicaid Approved/Pending - \$80/day)

Also included in the room and board rates: gloves, routine medical equipment (wheelchair, toilet riser, gerichair, commode, IV pole, cardiac chair), isolation supplies, protective devices (hipster, geri-sleeves, secure care bracelets), personal care items (facility-provided shampoo, toothpaste, deodorant, shaving cream, razor, urinal, anti-embolism stocking, ace bandages, peri-cream, ointment, slippers), skin ointment/swabs, test supplies (other than glucose) injections other than insulin, safety belts, positioning devices (bed & wheelchair wedges), pressure reducing devices (heel/elbow pad/protector, wheelchair cushions/pad).

Additional Services (not covered by Room and Board): Pharmacy and Medications, Beauty and Barbers Services, Private Duty Sitters, Transportation, Physician Visits, Respiratory Services, Specialty Power Wheelchairs, Orthotics, Diagnostic Services (eg, Lab and X-Ray) are billed by the Provider directly to Patient or Legal Representative. Payment may be due at the time services are rendered.

Rehabilitation Services:

Physical Therapy	\$55.00 per unit (15 min.)	Guest Meals	\$4.00 per meal
Occupational Therapy	\$55.00 per unit (15 min.)	Private Room upcharge (for Medicare/Insurance stays)	\$25.00 per day
Speech Therapy	\$55.00 per unit (15 min.)	Laundry	Free

Personal Choice Requests:

Wound Treatment Bundles

Wound Treatment	\$15.00 per occurrence	IV Therapy-Start	\$20.00 per occurrence
Complex Wound Treatment	\$50.00 per occurrence	IV Therapy – Supplies	\$12.50 Daily
Wound-Vac (single)	\$145.00 Daily	Level 1 APM Mattress	\$17.00 Daily
Wound-Vac (Two)	\$176.00 Daily	Level 2 Mattress w/pump	\$48.00 Daily
		Clinitron Bed	\$140.00 Daily rental

IV Care and Specialty Supportive Surfaces

Nutritional Supplemental Therapy

Based upon physician's orders	\$0.50 to \$7.00 per supplement	Glucose Finger Stick Monitoring	\$4.25 per occurrence
Enteral Feeding Supplies	\$15.75 Daily	Incontinence Fee	\$5.75 Daily

Other Services

Equipment & Treatments

Oxygen Concentrator Rental	\$8.50 Daily	Nebulizer Treatment	\$6.56/Treatment
Oxygen Services	\$11.00 Daily	Tracheostomy Care	\$36.00 Daily
CRAP/RIPAP	Daily Rate	Ostomy Care	\$7.00 per occurrence
Suction	Daily Rate	Catheter Care	\$23.00 per occurrence

Plaintiff Exhibit 1

Respondent Claim 1 Exhibit 1